FOR OHF USE

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2000
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2000)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0024836

Facility Name: Heritage Fifty-Three

Address: 4016 Ninth Street (Number) | Rock Island , Illinois (City) | 61201 (Zip Code)

County: Rock Island

Telephone Number: (309) 786-6474 **Fax #** (309) 786-9861

IDPA ID Number: 362615996001

Date of Initial License for Current Owners: 11/13/79

Type of Ownership:

x	VOLUNTARY,NON-PROFIT		PROPRIETARY		GOVERNMENTAL
x	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code 503c			Corporation		Other
			"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Dave Daughtery **Telephone Number:** (309) 786-6474

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 070199 to 063000 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider

(Signed) _____ (Date)

(Type or Print Name) Kyle Rick

(Title) Associate Executive Director

Paid Preparer

(Signed) _____ (Date)

(Print Name and Title)

(Firm Name & Address)

(Telephone) ( ) Fax # ( )

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 **Phone # (217) 782-1630**

Facility Name & ID Number Heritage Fifty-Three # 0024836 Report Period Beginning: 070199 Ending: 063000

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds 64

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1		Skilled (SNF)			1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4	64	Intermediate/DD	64	23,360	4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	64	TOTALS	64	23,360	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF					8
9	SNF/PED					9
10	ICF					10
11	ICF/DD	23,200			23,200	11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	23,200			23,200	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 99.32%

D. How many bed-hold days during this year were paid by Public Aid?
160 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
none

F. Does the facility maintain a daily midnight census? yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [x]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [x]

I. On what date did you start providing long term care at this location?
Date started 11/13/79

J. Was the facility purchased or leased after January 1, 1978?
YES [x] Date 11/13/79 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [ ] NO [x] If YES, enter number of beds certified _____ and days of care provided _____

Medicare Intermediary _____

IV. ACCOUNTING BASIS

ACCRUAL [x] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [x] NO [ ]

Tax Year: 06/30/00 Fiscal Year: 06/30/00

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number Heritage Fifty-Three # 0024836 Report Period Beginning: 070199 Ending: 063000

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger Salary/Wage 1	Supplies 2	Other 3	Total 4	Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY 9	10	
	A. General Services											
1	Dietary	187,039	4,719	3,427	195,185		195,185		195,185			1
2	Food Purchase		133,835		133,835	(26,950)	106,885	835	107,720			2
3	Housekeeping	78,603	11,843		90,446		90,446	182	90,628			3
4	Laundry	13,372	16,112		29,484		29,484		29,484			4
5	Heat and Other Utilities			68,696	68,696		68,696	1,091	69,787			5
6	Maintenance	57,267	31,499	4,815	93,581		93,581	1,992	95,573			6
7	Other (specify):*											7
8	**TOTAL General Services**	336,281	198,008	76,938	611,227	(26,950)	584,277	4,100	588,377			8
	B. Health Care and Programs											
9	Medical Director			4,450	4,450		4,450		4,450			9
10	Nursing and Medical Records	357,117	32,476	2,133	391,726		391,726	2	391,728			10
10a	Therapy											10a
11	Activities		1,372	3,211	4,583		4,583		4,583			11
12	Social Services	50,255			50,255		50,255		50,255			12
13	Nurse Aide Training	82,734	1,700		84,434		84,434		84,434			13
14	Program Transportation		6,244		6,244		6,244		6,244			14
15	Other (specify):* habilation aids	841,833	6,587		848,420		848,420		848,420			15
16	**TOTAL Health Care and Programs**	1,331,939	48,379	9,794	1,390,112		1,390,112	2	1,390,114			16
	C. General Administration											
17	Administrative	60,729			60,729		60,729	157,601	218,330			17
18	Directors Fees											18
19	Professional Services			11,419	11,419		11,419	14,282	25,701			19
20	Dues, Fees, Subscriptions & Promotions			18,101	18,101		18,101	10,199	28,300			20
21	Clerical & General Office Expenses	26,198	10,719	5,867	42,784		42,784	7,216	50,000			21
22	Employee Benefits & Payroll Taxes			376,045	376,045	26,950	402,995	30,582	433,577			22
23	Inservice Training & Education							1,367	1,367			23
24	Travel and Seminar			2,548	2,548		2,548	1,360	3,908			24
25	Other Admin. Staff Transportation		2,672		2,672		2,672	2,301	4,973			25
26	Insurance-Prop.Liab.Malpractice			31,195	31,195		31,195	1,877	33,072			26
27	Other (specify):*											27
28	**TOTAL General Administration**	86,927	13,391	445,175	545,493	26,950	572,443	226,785	799,228			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	1,755,147	259,778	531,907	2,546,832		2,546,832	230,887	2,777,719			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number Heritage Fifty-Three #0024836 Report Period Beginning: 070199 Ending: 063000

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	D. Ownership											
30	Depreciation			123,518	123,518		123,518	4,198	127,716			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			4,340	4,340		4,340	264	4,604			32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	**TOTAL Ownership**			127,858	127,858		127,858	4,462	132,320			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers											39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			168,444	168,444		168,444		168,444			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**			168,444	168,444		168,444		168,444			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	1,755,147	259,778	828,209	2,843,134		2,843,134	235,349	3,078,483			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number Heritage Fifty-Three # 0024836 Report Period Beginning: 070199 Ending: 063000

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(688)	20		24
25	Fund Raising, Advertising and Promotional				25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule				29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (688)		$	30

OHF USE ONLY								
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	236,037		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 236,037		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ 235,349		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		x	$		38
39						39
40	Gift and Coffee Shops		x			40
41	Barber and Beauty Shops		x			41
42	Laboratory and Radiology		x			42
43	Prescription Drugs		x			43
44	Exceptional Care Program		x			44
45	Other-Attach Schedule		x			45
46	Other-Attach Schedule		x			46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

STATE OF ILLINOIS

Heritage Fifty-Three

ID# 0024836

Report Period Beginning: 070199

Ending: 063000

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1		$		1
2				2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
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31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49				49
50				50
51				51
52				52
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61				61
62				62
63				63
64				64
65				65
66				66
67				67
68				68
69				69
70				70
71				71
72				72
73				73
74				74
75				75
76				76
77				77
78				78
79				79
80				80
81				81
82				82
83				83
84				84
85				85
86				86
87				87
88				88
89				89
90	Total	0		90

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Heritage Fifty-Three # 0024836 Report Period Beginning: 070199 Ending: 063000

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	0	835	0	0	0	0	0	0	0	0	0	835	2
3	Housekeeping	0	182	0	0	0	0	0	0	0	0	0	182	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	1,091	0	0	0	0	0	0	0	0	0	1,091	5
6	Maintenance	0	1,992	0	0	0	0	0	0	0	0	0	1,992	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	0	4,100	0	0	0	0	0	0	0	0	0	4,100	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	2	0	0	0	0	0	0	0	0	2	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	0	2	0	0	0	0	0	0	0	0	2	16
	C. General Administration													
17	Administrative	0	157,601	0	0	0	0	0	0	0	0	0	157,601	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	14,282	0	0	0	0	0	0	0	0	0	14,282	19
20	Fees, Subscriptions & Promotions	(688)	10,887	0	0	0	0	0	0	0	0	0	10,199	20
21	Clerical & General Office Expenses	0	7,216	0	0	0	0	0	0	0	0	0	7,216	21
22	Employee Benefits & Payroll Taxes	0	30,582	0	0	0	0	0	0	0	0	0	30,582	22
23	Inservice Training & Education	0	1,367	0	0	0	0	0	0	0	0	0	1,367	23
24	Travel and Seminar	0	1,360	0	0	0	0	0	0	0	0	0	1,360	24
25	Other Admin. Staff Transportation	0	0	2,301	0	0	0	0	0	0	0	0	2,301	25
26	Insurance-Prop.Liab.Malpractice	0	0	1,877	0	0	0	0	0	0	0	0	1,877	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	(688)	223,295	4,178	0	0	0	0	0	0	0	0	226,785	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(688)	227,395	4,180	0	0	0	0	0	0	0	0	230,887	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Heritage Fifty-Three # 0024836 **Report Period Beginning:** 070199 **Ending:** 063000

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	D. Ownership													
30	Depreciation	0	0	4,198	0	0	0	0	0	0	0	0	4,198	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	0	264	0	0	0	0	0	0	0	0	264	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	0	0	4,462	0	0	0	0	0	0	0	0	4,462	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	0	0	0	0	0	0	0	0	0	0	0	0	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(688)	227,395	8,642	0	0	0	0	0	0	0	0	235,349	45

Facility Name & ID Number Heritage Fifty-Three # 0024836 Report Period Beginning: 070199 Ending: 063000

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
none						

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [ ] YES [x] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	2	Food and Beverage	$	ARC/RIC	100.00%	$ 835	$ 835	1
2	V	3	Housekeeping		ARC/RIC	100.00%	182	182	2
3	V	5	Utilities		ARC/RIC	100.00%	1,091	1,091	3
4	V	6	Maintence		ARC/RIC	100.00%	1,992	1,992	4
5	V	19	Account/consultant		ARC/RIC	100.00%	10,053	10,053	5
6	V	19	Legal Fees		ARC/RIC	100.00%	4,229	4,229	6
7	V	17	Administration Salaries		ARC/RIC	100.00%	157,601	157,601	7
8	V	20	Sub/promotion/Printing		ARC/RIC	100.00%	10,887	10,887	8
9	V	21	Office Expense		ARC/RIC	100.00%	4,599	4,599	9
10	V	21	Telephone		ARC/RIC	100.00%	2,617	2,617	10
11	V	22	Employee Benefits		ARC/RIC	100.00%	30,582	30,582	11
12	V	23	Staff Training		ARC/RIC	100.00%	1,367	1,367	12
13	V	24	Travel Seminar		ARC/RIC	100.00%	1,360	1,360	13
14	Total			$			$ 227,395	$ * 227,395	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number Heritage Fifty-Three # 0024836 Report Period Beginning: 070199 Ending: 063000

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
	Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V		25	Other Administration,staff Transport	$	ARC/RIC	100.00%	$ 2,301	$ 2,301	15
16	V		26	Insurance/Prof/Liability		ARC/RIC	100.00%	1,877	1,877	16
17	V		32	Interest mortgage		ARC/RIC	100.00%	264	264	17
18	V		30	Depreciation		ARC/RIC	100.00%	4,198	4,198	18
19	V		10	medical hygine supplies		ARC/RIC	100.00%	2	2	19
20	V									20
21	V									21
22	V									22
23	V									23
24	V									24
25	V									25
26	V									26
27	V									27
28	V									28
29	V									29
30	V									30
31	V									31
32	V									32
33	V									33
34	V									34
35	V									35
36	V									36
37	V									37
38	V									38
39	Total				$			$ 8,642	$ * 8,642	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number Heritage Fifty-Three # 0024836 Report Period Beginning: 070199 Ending: 063000

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	none								$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number Heritage Fifty-Three # 0024836 Report Period Beginning: 070199 Ending: 063000

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [x] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: Association for Retarded Citizens
Street Address: 4016 9th Street
City / State / Zip Code: Rock Island , Illinois
Phone Number: ((309) 786-6474
Fax Number: ((309) 786-9861

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	2	Food and Beverage	The percent of Budgeted	865,446	16 programs	$ 2,496	$	289,628	$ 835	1
2	3	Housekeeping	Administrative Costs are	865,446	16 programs	544		289,628	182	2
3	5	Utilities	to be allocated based on	865,446	16 programs	3,260		289,628	1,091	3
4	6	Maintenance	percentage of salary	865,446	16 programs	5,951		289,628	1,992	4
5	19	Accountant/consultants		865,446	16 programs	30,041		289,628	10,053	5
6	19	Legal Fees		865,446	16 programs	12,637		289,628	4,229	6
7	17	Administration salaries		865,446	16 programs	470,932	470,932	289,628	157,601	7
8	20	Sub/promotion/printing		865,446	16 programs	32,533		289,628	10,887	8
9	21	Office expense		865,446	16 programs	13,741		289,628	4,599	9
10	21	Telephone		865,446	16 programs	7,821		289,628	2,617	10
11	22	Employee Benefits		865,446	16 programs	91,384		289,628	30,582	11
12	10	Medical/hygine supplies		865,446	16 programs	5		289,628	2	12
13	23	Staff/training		865,446	16 programs	4,084		289,628	1,367	13
14	24	Travel Seminar		865,446	16 programs	4,065		289,628	1,360	14
15	25	Other Administration,staff Transportation		865,446	16 programs	6,877		289,628	2,301	15
16	26	Insurance/prof/liability		865,446	16 programs	5,608		289,628	1,877	16
17	32	Interest mortgage		865,446	16 programs	790		289,628	264	17
18	30	Depreciation		865,446	16 programs	12,543		289,628	4,198	18
19	35									19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 705,312	$ 470,932		$ 236,037	25

Facility Name & ID Number Heritage Fifty-Three # 0024836 Report Period Beginning: 070199 Ending: 063000

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1	none						$	$			$	1
2												2
3												3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related						$	$			$	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$	$			$	15

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number Heritage Fifty-Three # 0024836 **Report Period Beginning:** 070199 **Ending:** 063000

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 1999 report.	$	none	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$		2
3. Under or (over) accrual (line 2 minus line 1).	$	#VALUE!	3
4. Real Estate Tax accrual used for 2000 report. (Detail and explain your calculation of this accrual on the lines below.)	$		4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**	$		5
6. Subtract a refund of real estate taxes used previously to calculate a payment rate. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For 19 Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**	$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	$	#VALUE!	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
	1995	8
	1996	9
	1997	10
	1998	11
	1999	12

FOR OHF USE ONLY

13	FROM R. E. TAX STATEMENT FOR 1999	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

Facility Name & ID Number Heritage Fifty-Three # 0024836 Report Period Beginning: 070199 Ending: 063000

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 30,076 B. General Construction Type: Exterior Brick Frame Steel Construction Number of Stories 1

C. Does the Operating Entity? [x] (a) Own the Facility [ ] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [x] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [ ] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

none

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [x] NO
If so, please complete the following:

1. Total Amount Incurred: none
2. Number of Years Over Which it is Being Amortized:
3. Current Period Amortization:
4. Dates Incurred:

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	DD Facility	196,020	1980	$ 98,594	1
2					2
3	TOTALS	196,020		$ 98,594	3

Facility Name & ID Number Heritage Fifty-Three # 0024836 Report Period Beginning: 070199 Ending: 063000

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	64		1980	1979	$ 2,266,810	$ 56,787	40	$ 56,787	$ 0	$ 1,161,798	4
5	Grage		1998	1998	9,995	317	31.5	317		793	5
6											6
7											7
8											8
	Improvement Type**										
9	Shower Renovation			1985	92,597	4,657	20	4,657		72,031	9
10	Remodeled Restrooms/Aspahlt driveway			1986	6,987	349	20	349		6,531	10
11	Remodel Kitchen			1988	4,339					4,339	11
12	Asphalt Parking lot /Remodel Kitchen #2			1989	17,029					17,029	12
13	Airconditioning Kitchen			1992	5,650	565	31.5	565		4,803	13
14	Roof Repair Asphalt ,Remodeling			1993	16,809	664	31.5	664		4,852	14
15	Plumbing Repairs/Sidewalk Ramp			1994	8,220	487	31.5	487		2,890	15
16	Roofand Hot water system			1995	22,625	1,385	31.5	1,385		7,017	16
17	new hot water system			1996	50,449	1,149	31.5	1,149		5,170	17
18	hot water continuation			1997	35,175	1,116	315	1,116		3,906	18
19	hot water continuation			1997	4,202	210	315	210		630	19
20	parking lot blacktop			1997	3,430	224	31.5	224		672	20
21	Shoper Driveway fire alarm water tank tub			1998	32,520	1,032	31.5	1,032		1,548	21
22	Air/Firedoors,concrete walks,fuelstoragetank			1999	35,720	568	31.5	568		568	22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	TOTAL (lines 4 thru 35)				$ 2,612,557	$ 69,510		$ 69,510	$ 0	$ 1,294,577	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Heritage Fifty-Three # 0024836 Report Period Beginning: 070199 Ending: 063000

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
37	Purchased in Prior Years	$ 239,910	$ 47,416	$ 47,416	$		$ 164,081	37
38	Current Year Purchases	47,701	4,770	4,770			4,770	38
39	Fully Depreciated Assets	243,610						39
40								40
41	TOTALS	$ 531,221	$ 52,186	$ 52,186	$		$ 168,851	41

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
42	Patient care van	94 lift van	1997	$ 18,060	$ 6,020	$ 6,020	$	3	$ 15,050	42
43										43
44										44
45										45
46	TOTALS			$ 18,060	$ 6,020	$ 6,020	$		$ 15,050	46

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
47	Total Historical Cost	(line 3,col.4 + line 36,col.4 + line 41,col.1 + line 46,col.4)	$ 3,260,432	47
48	Current Book Depreciation	(line 36,col.5 + line 41,col.2 + line 46,col.5)	$ 127,716	48
49	Straight Line Depreciation	(line 36,col.7 + line 41,col.3 + line 46,col.6)	$ 127,716	49 **
50	Adjustments	(line 36,col.8 + line 41,col.4 + line 46,col.7)	$ 0	50
51	Accumulated Depreciation	(line 36,col.9 + line 41,col.6 + line 46,col.9)	$ 1,478,478	51

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
52		$ 18,060	$ 6,020	$ 6,020	52
53					53
54					54
55					55
56					56
57	TOTALS	$ 18,060	$ 6,020	$ 6,020	57

G. Construction-in-Progress

	Description	Cost	
58		$	58
59			59
60			60
61		$	61

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: none

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease ____.

9. Option to Buy: ☐ YES ☐ NO Terms: ____ *

10. Effective dates of current rental agreement:
Beginning ____
Ending ____

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2001	$
13.	/2002	$
14.	/2003	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☐ NO

16. Rental Amount for movable equipment: $ Description:
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number Heritage Fifty-Three # 0024836 Report Period Beginning: 070199 Ending: 063000

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? [x] YES [ ] NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM: 29
   - IN OTHER FACILITY:
   - COMMUNITY COLLEGE:
   - HOURS PER AIDE: 40

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM: 29
   - IN OTHER FACILITY:
   - HOURS PER AIDE: 80

B. EXPENSES

ALLOCATION OF COSTS (d)

			1 Facility Drop-outs	2 Facility Completed	3 Contract	4 Total
1	Community College Tuition		$	$	$	$
2	Books and Supplies		752	948		1,700
3	Classroom Wages	(a)	2,732	8,237		10,969
4	Clinical Wages	(b)	4,372	14,917		19,289
5	In-House Trainer Wages	(c)	12,248	40,228		52,476
6	Transportation					
7	Contractual Payments					
8	Nurse Aide Competency Tests					
9	TOTALS		$ 20,104	$ 64,330	$	$ 84,434
10	SUM OF line 9, col. 1 and 2	(e)	$ 84,434			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	29
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	17
2. From other facilities (f)	
TOTAL TRAINED	46

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	none	hrs	$		$	$		$	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs							4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescrpts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):									13
14	TOTAL			$		$	$		$	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

Facility Name & ID Number Heritage Fifty-Three # 0024836 **Report Period Beginning:** 070199 **Ending:** 063000

XV. BALANCE SHEET - Unrestricted Operating Fund. **As of** 063000 **(last day of reporting year)**

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 258,021	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	290,785		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments	67,984		5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	190		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 616,980	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	98,594		13
14	Buildings, at Historical Cost	2,612,557		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	549,281		16
17	Accumulated Depreciation (book methods)	(1,478,478)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 1,781,954	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 2,398,934	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 55,937	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	271,733		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36				36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 327,670	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation	23,239		42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 23,239	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 350,909	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 2,048,025	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 2,398,934	$	48

***(See instructions.)**

Facility Name & ID Number Heritage Fifty-Three # 0024836 Report Period Beginning: 070199 Ending: 063000

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total		
1	**Balance at Beginning of Year, as Previously Reported**	$ 2,177,200	1	
2	Restatements (describe):		2	
3	**Reclassification of Fixed Assets**	(226,484)	3	
4			4	
5			5	
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 1,950,716	6	
	A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	97,309	7	
8	Aquisitions of Pooled Companies		8	
9	Proceeds from Sale of Stock		9	
10	Stock Options Exercised		10	
11	Contributions and Grants		11	
12	Expenditures for Specific Purposes		12	
13	Dividends Paid or Other Distributions to Owners	( )	13	
14	Donated Property, Plant, and Equipment		14	
15	Other (describe)		15	
16	Other (describe)		16	
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 97,309	17	
	B. Transfers (Itemize):			
18			18	
19			19	
20			20	
21			21	
22			22	
23	**TOTAL Transfers (sum of lines 18-22)**	$	23	
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 2,048,025	24	*

*** This must agree with page 17, line 47.**

Facility Name & ID Number Heritage Fifty-Three # 0024836 Report Period Beginning: 070199 Ending: 063000

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 2,890,891	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 2,890,891	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$	8
	C. Other Operating Revenue		
9	Payments for Education	420	9
10	Other Government Grants	1,800	10
11	Nurses Aide Training Reimbursements	8,978	11
12	Gift and Coffee Shop	4,224	12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space	3,012	16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services	7,058	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 25,492	23
	D. Non-Operating Revenue		
24	Contributions	5,683	24
25	Interest and Other Investment Income***	18,377	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 24,060	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 2,940,443	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	274,946	31
32	Health Care	58,173	32
33	General Administration	2,213,713	33
	B. Capital Expense		
34	Ownership	127,858	34
	C. Ancillary Expense		
35	Special Cost Centers		35
36	Provider Participation Fee	168,444	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 2,843,134	40
41	**Income before Income Taxes (line 30 minus line 40)****	97,309	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 97,309	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? yes If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

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XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	541	601	$ 10,226	$ 17.01	1
2	Assistant Director of Nursing					2
3	Registered Nurses	333	333	4,633	13.91	3
4	Licensed Practical Nurses	14,564	15,830	184,148	11.63	4
5	Nurse Aides & Orderlies					5
6	Nurse Aide Trainees	7,691	8,544	64,937	7.60	6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants					10
11	Social Service Workers					11
12	Dietician					12
13	Food Service Supervisor	2,028	2,248	22,043	9.81	13
14	Head Cook					14
15	Cook Helpers/Assistants	6,007	6,675	49,642	7.44	15
16	Dishwashers	15,217	16,362	115,354	7.05	16
17	Maintenance Workers	5,751	6,184	57,267	9.26	17
18	Housekeepers	10,418	11,740	78,603	6.70	18
19	Laundry	1,982	2,131	13,372	6.27	19
20	Administrator	1,240	1,334	26,829	20.11	20
21	Assistant Administrator	1,952	2,296	33,900	14.76	21
22	Other Administrative					22
23	Office Manager	1,944	2,248	20,907	9.30	23
24	Clerical	580	624	5,291	8.48	24
25	Vocational Instruction					25
26	Academic Instruction	1,099	1,195	17,797	14.89	26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)	4,159	4,472	50,255	11.24	28
29	Resident Services Coordinator	14,634	15,736	158,110	10.05	29
30	Habilitation Aides (DD Homes)	101,905	110,767	841,833	7.60	30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	192,045	209,320	$ 1,755,147 *	$ 8.38	34

* This total must agree with page 4, column 1, line 45. ** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	137	$ 3,427	L1C3	35
36	Medical Director	annual	4,450	L9C3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	21	522	L10C3	39
40	Physical Therapy Consultant	40	1,010	L10C3	40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	6	143	L10C3	43
44	Activity Consultant				44
45	Social Service Consultant				45
46	Other(specify) Psychological	23	458	L10C3	46
47					47
48					48
49	TOTAL (lines 35 - 48)	227	$ 10,010		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$		50
51	Licensed Practical Nurses				51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)		$		53

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XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Kevin Feeney	Administrator		$ 33,900
Karen Steen	Assoc Exect. Dir		26,829
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 60,729

B. Administrative - Other

Description	Amount
	$
TOTAL (agree to Schedule V, line 17, col. 3)	$
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
		$
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 20,726
Unemployment Compensation Insurance	0
FICA Taxes	131,203
Employee Health Insurance	108,116
Employee Meals	26,950
Illinois Municipal Retirement Fund (IMRF)*	
Pension Expense Employer Pd	109,160
Disability Insurance	2,252
Group Term Insurance	3,710
Admin Fringe Benefits From	30,582
Schedule VIII line 11 c 9	
Immunization Costs	878
TOTAL (agree to Schedule V, line 22, col.8)	$ 433,577

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

* Attach copy of IMRF notifications

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 300
Advertising: Employee Recruitment	11,305
Health Care Worker Background Check	
(Indicate # of checks performed)	
Subscriptions	353
Arc/Il and Us Dues	8,450
Staff Awards and Promotions	7,543
Direct Deposit Fees	349
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 28,300

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	3,908
Seminar Expense	
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 3,908

**See instructions.

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XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY1997	FY1998	FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005
1	none		$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

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XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? yes

(2) Are there any dues to nursing home associations included on the cost report? no
If YES, give association name and amount.

(3) Did the nursing home make political contributions or payments to a political action organization? no If YES, have these costs been properly adjusted out of the cost report?

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? no If YES, what is the capacity?

(5) Have you properly capitalized all major repairs and equipment purchases? yes
What was the average life used for new equipment added during this period?

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ none Line

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? yes If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? no
If YES, give effective date of lease.

(9) Are you presently operating under a sublease agreement? YES x NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO x If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ 168,444
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? no If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? yes

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? no For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ 26,950 Has any meal income been offset against related costs? no Indicate the amount. $ 0

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? yes
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? no If YES, please indicate the amount of income earned from such a program during this reporting period. $ none
c. What percent of all travel expense relates to transportation of nurses and patients?
d. Have vehicle usage logs been maintained? yes
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? yes
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report?
g. Does the facility transport residents to and from day training? no
Indicate the amount of income earned from providing such transportation during this reporting period. $ none

(17) Has an audit been performed by an independent certified public accounting firm? yes
Firm Name: Crippen , Reid and Bowen L.L.C. The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? yes If no, please explain.

(18) Have all costs which do not relate to the provision of long term care been adjusted out out of Schedule V? yes

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? yes
Attach invoices and a summary of services for all architect and appraisal fees.